

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11102

11318

194

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County HowardCity or town Near Glenwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Minnie V. Beasman

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife George E. Beasman7. Birth date of deceased (mo., day, yr.) March 6, 1873

6. (c) If alive, give age years

8. AGE: Years 74 Months 8 Days 30 If less than one day hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name Jacob Trayer13. Birthplace Maryland14. Maiden name Anne V. Bennett15. Birthplace Maryland16. Informant Mrs. Raymond FlohrAddress Glenwood, Md.17. Burial Date thereof Dec. 8, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak GroveLocation Glenwood, Md.18. Funeral director C. Harry WeerAddress Sykesville, Md.19. Dec 6 1947  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Near Glenwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1948 19 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 15 1946 to December 5 1947and that I last saw her alive on December 5 1947

Immediate cause of death

Acute circulatory failure DURATION 8 hoursDue to Pulmonary embolism 8 hours

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

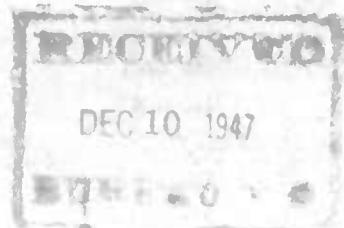
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D. M. D. or otherAddress Clarksville, Md. Date signed 12-6-47



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH166  
Registered No. 11311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 (a) Baltimore City, Maryland *Howard*  
 (b) Street address *Meadowridge Road. Elkridge,*  
 (c) Hospital or institution: *1*

(d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State *Md.* (b) County *Howard*  
 (c) City or town *Elkridge*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *Meadowridge Road-*  
 (If rural give location)  
 (e) Citizen of foreign country? *Yes or No*  
 If yes, name country

3 (a) FULL NAME

WILLIAM DAVIS

3 (b) If veteran, name war *None* 3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *Colored* 6 (a) Single, married, widowed, or divorced. *7*

6 (b) Name of husband or wife *None* 6 (c) If alive, give age *years*

7. Birth date of deceased (mo., day, yr.) *1897*

8. AGE: Years *50* Months *0* Days *0* If less than one day *hr. 0 min.*

9. Birthplace *North Carolina*  
(Town, county, and state)10. Usual Occupation *Labourer*

11. Industry or business

MOTHER **FATHER** 12. Name *Unknown*

13. Birthplace *11*14. Maiden Name *11*15. Birthplace *11*

16 (a) Informant *Carl Brown*  
 (b) Address *Elkridge, Md*

17 (a) Removal for Burial *Removal for Burial* (b) Date thereof *1-1-47*  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Berkeley*  
 Location *Norfolk Va.*

18 (a) Funeral director *P. J. McInerney*  
 (b) Address *Elkridge, Md*

19 (a) *1 1947* (b) *1947*  
 (Date rec'd by registrar) (Date of death)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 29, 1947, at 4:30 P.M.*

21. I certify that I took charge of the remains described above, held an autopsy *None* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined  and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

*Bullet wound of chest*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary  or contributing  cause of death, fill in the following:

(a) Date of injury *12-29-47* at *4 P.M.*  
 (b) Where did injury occur? *Meadowridge Rd. Elkridge, Md*

(c) Did injury occur at home, on farm, industrial place, in public place? *Home* While at work? *No*

(d) Means of injury *Firearms* *Carl Brown* M.D.

23. Signature *Carl Brown* M.D.  
 Medical ExaminerDate signed *12-30-47*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11320

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Howard Co  
 County: Elkridge Md  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:   
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Md County: Howard  
 City or town: Elkridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:   
 (If rural, give LOCATION)

3. (a) FULL NAME: Catherine A. Force (Force)  
 4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Wedowed  
 6. (b) Name of husband or wife: Charles Force  
 7. Birth date of deceased (mo., day, yr.): Aug. 14-1876 6. (c) If alive, give age: years  
 8. AGE: 71 Years  Months  Days  If less than one day  hrs.  min.  
 9. Birthplace: California (Town, county, and state) Los Angeles  
 10. Usual occupation: Housewife  
 11. Industry or business: Dental Supply  
 12. Name: Daniel Getekell  
 13. Birthplace: Germany  
 14. Maiden name: Caroline Mueller  
 15. Birthplace: Germany  
 16. Informant: Daughter Mrs. M. Tolson  
 Address: 1720 St. Augustine  
 17. Burial, cremation, or removal. Which? Burial Date thereof: Dec 2-47  
 (month) (day) (year)  
 Cemetery or crematory: St. Augustine Cem  
 Location: Elkridge Md.  
 18. Funeral director: Bob B. Henry  
 Address: 235 Astor

19. 12-31 19..... 57 Passenger  
 (Date rec'd by registrar)

Registrar

2. (a) If veteran, name war:

3. (b) Social Security Number: 

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 19 47 4<sup>30</sup>P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 47 to Dec 29 19 47 and that I last saw her alive on Dec 29 19 47

Immediate cause of death: Arteric Myocarditis DURATION 2yr

Due to: Arterio - sclerosis DURATION 2yr

Due to:  DURATION

Other conditions:  (Include pregnancy within 3 months of death)

Major findings of operations:  Date of op.

Autopsy results:  PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of:

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, Industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE: W. L. Tolson M.D. M. D. or other

Address: 1711 Selby Ave Date signed 1/31/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Supply every item of information carefully. Please write the causes of death clearly and legibly. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11321

## CERTIFICATE OF DEATH

93d  
Reg. Dlat. No. 195

## 1. PLACE OF DEATH:

County

Howard  
Savage

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3.5 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Annie Mary Grafton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. M. Single

## 6. (b) Name of husband or wife

George W. Grafton

## 7. Birth date of deceased (mo., day, yr.)

May 18 1873

6. (c) If alive, give age years

## 8. AGE:

74 Years 7 Months 0 Days If less than one day

hrs.

min.

## 9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Home

Daley

## 12. Name

—

## 13. Birthplace

—

## 14. Maiden name

—

## 15. Birthplace

—

## 16. Informant

Mrs. Anna Louise O'Keefe

Severn Md.

## Address

Burial

Date thereof the 20.1947

(month) (day) (year)

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Poplars Grove

## Location

Harbor Md.

## Funeral director

H. H. Stett Womble

## Address

Savage Md.

## 19. (Date recd by registrar)

12/19/47

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Howard

City or town

Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec. 18 1947 2 P.M.

21. I CERTIFY that death occurred on the date above stated. I have attended deceased

Dec. 9 1947 to Dec. 18 1947

and that I last saw her alive on Dec. 18 1947

## Immediate cause of death

acute Myocardial Insuff. -

Due to Hypertensive Cardiac -

Vascular Disease

## Due to

Hypertension

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

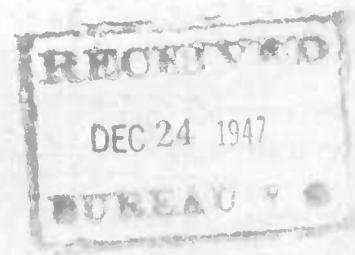
Means of injury Injured at work?

## 23. SIGNATURE

Frank Shiley, M.D.

M.D. or other

Address Savage Md. Date signed 12/19/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a

11322

Reg. Dist. No. 191

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Howard

City or town

Ellwood City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 years

Hospital, institution, or street address where death occurred:

Syphon Lane, Ellwood City, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

Elsie E Hall

4. Sex

f

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Rufus W Hall

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo. day. yr.)

Jan. 26 1890

8. AGE:

Years 57 Months 10 Days 12

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

Johns Brathers

12. Name

Johns Brathers

13. Birthplace

Md

14. Maiden name

Mary Waeber

15. Birthplace

Md

16. Informant

Rufus W Hall

Address

Ellwood City Md.

17. Burial

Date thereof 12.10.47

(Burial, cremation, or removal: Which?)

(month) (day) (year)

Cemetery or crematory

Poplar Springs

Location

Poplar Springs

18. Funeral director

J.C. Regent or Sons

Address

Ellwood City Md

19. Dec. 9

1847

(Date record is registered)

John B. Longman  
Reg. B. E. 2

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellwood City

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sylva Lane

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 8, 1947, 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 July 1946 to 7 December 1947

and that I last saw her alive on 5 December 1947

Immediate cause of death

Cachexia + General Debility

DURATION

2 weeks

Due to Extensive carcinoma

5 months

Due to carcinoma of liver

1 year

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William F. Garrison M.D.

M. D. or other

Address Ellwood City, Md. Date signed 8 Dec. 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

## CERTIFICATE OF DEATH

Reg. Dist. No....

198

## 1. PLACE OF DEATH:

Howard  
County.....Watersville  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

GEORGE F. HATFIELD

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Elizabeth A. Hatfield

82

## 7. Birth date of deceased (mo., day, yr.)

Nov. 4, 1864

6. (c) If alive, give age year

## 8. AGE:

83

Years

1

Months

12

Days

If less than one day

hrs.

min.

## 9. Birthplace

Howard Co. Maryland

(Town, county, and state)

retired

## 10. Usual occupation

B. &amp; O. R.R.

## 11. Industry or business

Daniel Hatfield

## 12. Name

Maryland

## 13. Birthplace

Rachel Gosnell

## 14. Maiden name

Maryland

## 15. Birthplace

Mrs. Elizabeth A. Hatfield

## 16. Informant

Mt. Airy, Md.

## Address

Burial

Date thereof 12-19-47

## (Burial, cremation, or removal, which?)

Poplar Springs

## Cemetery or crematory

Poplar Springs, Howard Co. Md.

## Location

C. M. Waltz

## 18. Funeral director

Winfield, Md.

## Addressee

19. 12-19-47  
(Date rec'd by registrar) 1947

E. Paul Morris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Howard

Watersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

December 16, 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 9, 1947, to December 16, 1947

and that I last saw him alive on December 16, 1947

## Immediate cause of death

Acute uremia

## DURATION

6 da

Due to Cardio-Renal-Vascular disease

? yrs

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

none

## Date of op.

## Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

## Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Stanley Grubill

Mt. Airy, Md. Date signed 12/16/47

M. D. or other

27 1947

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11324

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

W  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Howard  
County  
City or town.....Dayton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 70 years  
Hospital, Institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Howard  
City or town.....Dayton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 200 Maryland  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Howard Elendora Boyer

7. Birth date of deceased (mo., day, yr.) March 28, 1877 6.(c) If alive, give age 67 years

8. AGE: Years 70 Months 8 Days 13 If less than one day  
hrs. ..... min. ....

9. Birthplace Dayton, Md.  
(Town, county, and state)

10. Usual occupation Deputy Collector

11. Industry or business Internal Revenue

12. Name George Howard

13. Birthplace Howard Co., Md.

14. Maiden name Elizabeth Johnson

15. Birthplace Dayton, Md.

16. Informant Miss Louise Howard

Address Dayton, Md.

17. Date thereof Dec. 14, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marks Cem.

Location Highland, Md.

18. Funeral director Easton Sons

Address Ellicott City, Md.

19. 12-12-1947 Marie G. Whitaker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 11, 1947 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1947 to Dec. 10 1947 and that I last saw him alive on December 10 1947

Immediate cause of death

Acute cardiac failure DURATION  
2 days

Due to myocardial insufficiency 2 days

Due to coronary sclerosis 20 yrs

Other conditions angina pectoris 15 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of ....

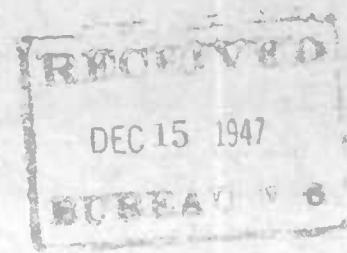
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Charles S. Wintah, M.D.  
M. D. or other

Address Clarksville, Md. Date signed 12-12-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11325

195

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

5700 Main St

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (d) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age .....

years

Sept 8 1918

8. AGE:

Years

Months

Days

If less than one day

29

3

18

hrs.

min.

9. Birthplace

(Town, county, and state)

Baltimore MD

10. Usual occupation

Bus. Manager

11. Industry or business

Dentist

12. Name

Raymond E. Knuth

13. Birthplace

Ohio

14. Maiden name

Genevieve M. Carr

15. Birthplace

Baltimore MD

16. Informant

Raymond E. Knuth

Address

Elmhurst

17. Burial, cremation, or removal. Which?

Final

Date thereof

(month) (day) (year)

Cemetery or crematory

Baltimore MD

Location

Million Park

18. Funeral director

1219 St Paul

Address

Nov 29 1947

A. W. Anderson

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Howard

City or town

Elmhurst

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5700

Main

St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 29 1947 a 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1940 to Dec 27 1947 and that I last saw him alive on Dec 27 1947

Immediate cause of death

Oulmonary tuberculosis

Due to

Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

H. C. Anderson M. D. or other

Address 1123 St Paul Date signed Dec 29 1947

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11326

## CERTIFICATE OF DEATH

164c  
Reg. Dist. No. 1931. PLACE OF DEATH: Howard  
County.....City or town.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? few hoursHospital, institution, or street address where death occurred: Dr. Woods of Clancy Road

How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME DONALD BEIRNE PUE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Annis C. Pue7. Birth date of deceased (mo., day, yr.) March 3, 1892 8. (c) If alive, give age 46 years8. AGE: 55 Years 9 Months 15 Days If less than one day hrs. min.9. Birthplace Howard Co. Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Robert Pue12. Name Maryland  
FATHER Mary Grundy13. Birthplace Maryland  
MOTHER Maryland14. Maiden name Mrs. Annis C. Pue  
15. Birthplace Woodbine, Md.16. Informant Burial Date thereof 12-27-47  
(Burial, cremation, or removal, where)17. Cemetery or crematory Oak Grove18. Location Glenwood, Howard Co. Md.19. Funeral director C. M. Waltz  
Address Winfield, Md.20. (Date rec'd by registrar) 12/27/47 2 Pearl Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County HowardCity or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 47 5P.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 24 47 1947 to Dec 24 47 1947 and that I last saw him alive on at his home at his home 1947Immediate cause of death Compound fracture of skull DURATION shortDue to Gunshot wound

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12-18-47Where did injury occur? Clancy Howard Md (City or town) Howard (County) Md (State)Injured at home, farm, industry, public place (where?) in frontMeans of injury Shotgun wound Injured at work? No23. SIGNATURE Alpha M. Herbert M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Ellicott City, Md. Date signed 12-24-47

RECEIVED

DEC 30 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

11327

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 192

## 1. PLACE OF DEATH:

County HowardCity or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alice Ann Redmond

## 3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Samuel T. Redmond

7. Birth date of deceased (mo., day, yr.)

Mar. 13, 1875(c) If alive, give age 83 years

8. AGE:

Years

Months

Days

If less than one day

7294

hrs.

mio.

9. Birthplace

Howard Co Md

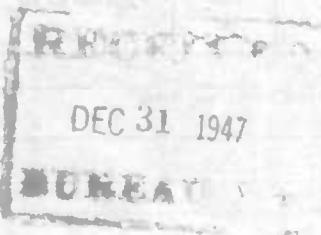
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct margin is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11328

195

Reg. Dist. No.

1. PLACE OF DEATH:  
County: Howard

City or town: Savage  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME  
Layrel Larson Smallwood

4. Sex: M | 5. Color or race: 26 | 6. (a) Single, married, widowed, or divorced: Divorced

7. Birth date of deceased (mo., day, yr.) Oct 7, 1916

6. (c) If alive, give age years

8. AGE: Years: 31 | Months: 3 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Calvert Clothing

12. Name: Norman C. Smallwood

13. Birthplace: Howard Co.

14. Maiden name: Louise C. Jones

15. Birthplace: Virginia

16. Informant: Layrel C. Smallwood

Address: Savage, Md.

17. Burial: Date thereof: Oct 27, 1947  
(Burial, cremation, or removal, which?)

Date thereof: (month) (day) (year)

Cemetery or crematory: Savage

Location: Savage, Md.

18. Funeral director: Calvert Clothing

Address: Layrel, Md.

19. Date rec'd by registrar: 12/27/47

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland | County: Howard

City or town: Savage  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

212-03-3839

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20, 1947, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st, 1947, to Dec. 25, 1947, and that I last saw him alive on Dec. 24, 1947.

Immediate cause of death: Pulmonary Tuberculosis DURATION: 2 yrs.

Due to: ✓

Due to: ✓

Other conditions: ✓

(Include pregnancy within 8 months of death)

Major findings or operations: ✓ Date of op. \_\_\_\_\_

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

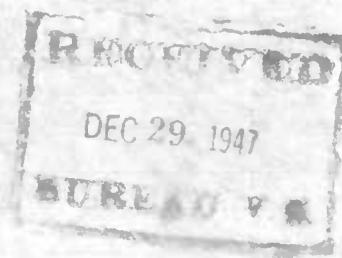
Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: Frank Shiley, M.D.

M. D. or other \_\_\_\_\_ Date signed 12/27/47

Address: Savage, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11329

87c

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County

Howard

City or town

Simpsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Velvia W. Thompson

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Robert B. Thompson

7. Birth date of deceased (mo., day, yr.)

July 2, 1868

6. (c) If alive, give age

89 years

8. AGE:

Years  
79Months  
5Days  
3If less than one day  
hrs. min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

John W. Sundall

12. Name

John W.

13. Birthplace

Catherine Holland

14. Maiden name

Holland

15. Birthplace

Md.

16. Informant

Edna Eversole

Address

Simpsonville Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof  
(month) (day) (year)

Cemetery or crematory

St. John's

Location

Ellicott City Md.

18. Funeral director

F. B. Biggs &amp; Son

Address

Ellicott City Md.

19. Date rec'd by registrar

Dec. 8, 1947

(Date rec'd by registrar)

John B. Longham

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Howard

City or town

Simpsonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Columbia Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 5, 1947 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1947, to December 5, 1947, and that I last saw her alive on December 5, 1947.

Immediate cause of death

Paralysis Agitans -

DURATION

2 yrs

Due to: cerebral arteriosclerosis

3 yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

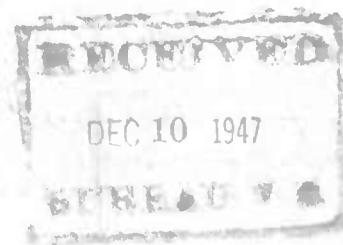
Evelyn A. Thompson, M.D.

M. D. or other

Address

Ellicott City Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11330

M4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County .....

Howard

City or town..... Near Clarksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Cedar Lane

How long in hospital or institution? .....

## 3. (a) FULL NAME

Henry Wagner

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife .....

None

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Dec. 6, 1877

8. AGE:

Years

Months

Days

If less than one day

70

-

12

hrs.

min.

8. Birthplace.....

Howard Co., Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Daniel Wagner

MOTHER FATHER

12. Name.....

Elisabeth Kraft

13. Birthplace.....

Germany

14. Maiden name.....

Elisabeth Kraft

15. Birthplace.....

Baltimore Co., Md.

16. Informant.....

Mrs. Esther M. W. J.

Address.....

Cedar Lane, Clarksville, Md.

17. Burial.....

Burial

Date thereof..... Dec. 21, 1947

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory.....

St. Paul's Cemetery

Location.....

Fultons, Md.

18. Funeral director.....

Castor's Sons

Address.....

Ellicott City, Md.

19. Date rec'd by registrar.....

Dec. 20, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Howard

City or town.....

Near Clarksville

Street No.....

Cedar Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 18, 1947, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25, 1946, to Dec. 18, 1947

and that I last saw h... in alive on Dec. 18, 1947

Immediate cause of death.....

Hypertension

DURATION

10 days

Due to.....

Nephrosclerosis

1 year

Due to.....

Generalized arteriosclerosis

10 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE..... Charles S. Whitaker, M.D.

M. D. or other

Address..... Clarksville, Md.

Date signed..... Dec. 19-47

